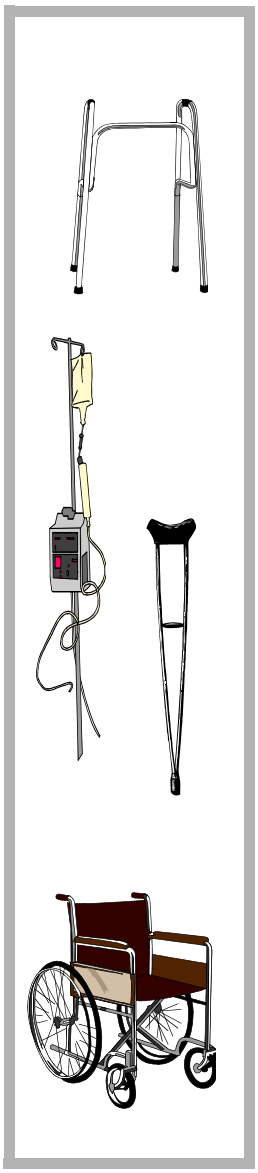

Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2005

This publication supersedes all previous Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS) handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

Updated January 2005, April 2005.

My Medicaid Provider ID Number:

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions or issues:

(406) 444-4068 Phone Program Officer
(406) 444-5296 Phone Claim Specialist
(406) 444-1861 Fax

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)

For coding advice and other SADMERC information:

(877) 735-1326
Mon-Fri 9:00 a.m.- 4:00 p.m. Eastern Time

SADMERC
P.O. Box 100143
Columbia, SC 29202-3143

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

Quality Assurance Division

For prior authorization for certain services (see the *Prior Authorization and PASSPORT* chapter in this manual) contact:

For clients with last names beginning with **A - K**, call:

(406) 444-3993 In/out-of-state

For clients with last names beginning with **L**, call:

(406) 444-6977 In/out-of-state

For clients with last names beginning with **M - Z**, call:

(406) 444-0190 In/out-of-state

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review Section
Prior Authorization
P.O. Box 202953
Helena, MT 59620-2953

Office of Management and Budget (OMB), and required by the Centers for Medicare & Medicaid Services (CMS). These forms are available in *Appendix A: Forms*, on the Provider Information website (see *Key Contacts*) and on the following websites:

http://www.cms.hhs.gov/providers/mr/cmn.asp

http://www.cignamedicare.com/dmerc/dmsm/C04/sm04_INDEX.html

The following is a list of items that require a CMN and the corresponding form. This reference list will be updated as changes are made. If any discrepancies exist between these referenced forms and what is published by CMS and Cigna Medicare, then the CMS and Cigna Medicare policy shall take precedence.

CMN Forms

Item	Form	Date
Enteral Nutrition	CMS-853	04/96
External Infusion Pump	CMS-851	04/96
Hospital Beds	CMS-841	04/96
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	05/97
Manual Wheelchairs	CMS-844	05/97
Motorized Wheelchairs	CMS-843	05/97
Osteogenesis Stimulators	CMS-847	05/97
Oxygen	CMS-484	11/99
Parenteral Nutrition	CMS-852	04/96
Power Operated Vehicles (POV)	CMS-850	04/96
Seat Lift Mechanisms	CMS-849	04/96
Section C Continuation Form	CMS-854	05/97
Support Surfaces	CMS-842	04/96
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	04/96

Rental/purchase (ARM 37.86.1801 - 1806)

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 12 months of rental reimbursement. After 12 months of continuous rental, the item is considered owned by the client and the provider must transfer ownership to the client. Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental are limited to 120% of the purchase price for that item. If purchasing the rental item is cost effective, the Department may cover the purchase of the item.

A statement of medical necessity for rental of DME equipment must indicate the length of time the equipment is needed, and all prescriptions must be signed and dated.

Servicing. During the 12-month rental period, Medicaid rental payment includes all supplies, maintenance, repair, components, adjustments and services related to the item during the rental month. Separately billable supply items identified and allowed by Medicare are also separately billable to Medicaid under the same limitations. No additional amounts related to the item may be billed or reimbursed for the item during the 12-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 12-month rental period when ownership of the item is transferred to the client, the provider may bill Medicaid for the supplies, maintenance, repair components, adjustment and services related to the items. Medicaid does not cover repair charges during the manufacturer's warranty period.

Items classified by Medicare as needing frequent and substantial servicing are covered on a monthly rental basis only. The 12-month rental limit does not apply and rental payment may continue as long as the item is medically necessary.

Interruptions in rental period. Interruptions in the rental period of less than 60 days will not result in the start of a new 12-month period or new 120% of purchase price limit. Periods in which service is interrupted do not count toward the 12-month rental limit.

Change in supplier. A change in supplier during the 12-month rental period will not result in the start of a new 12-month period or new 120% of purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the client; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written client statement that another supplier has not been providing the item, unless the provider has knowledge of other facts or information indicating that another supplier

has been providing the item. The supplier providing the item in the twelfth month of the rental period is responsible for transferring ownership to the client.

Change in equipment. If rental equipment is changed to different but similar equipment, the change will result in the start of a new 12-month period or new 120% of purchase price limit only when all of the following are met:

- The change in equipment is medically necessary as a result of a substantial change in the client's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

Non-covered services (ARM 37.86.1802)

The following are items and/or categories of items that are not covered through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by the U.S. Department of Health and Human Services, including the Medicare Program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items
- Items/services provided to a client in a nursing facility setting (see the *Nursing Facility Services* manual for details)

Verifying coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction

Use the current fee schedule for your provider type to verify coverage for specific services.

with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

No more than one month's medical supplies may be provided to a client at one time.

The following are specific criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Apnea Monitors

The rental of an apnea monitor will be covered initially for a six-month period from the date of the physician's order. Apnea monitors are covered under at least one of the following conditions:

- A sibling has died from SIDS
- Infant has symptomatic apnea
- Observation of apparent life-threatening events (ALTE)
- Infant is on oxygen
- Symptomatic apnea due to neurological impairment

For coverage after the initial six-month period, additional months coverage must be prior authorized by the Department and the following conditions must exist and be documented by the physician:

- Infant continues to have significant alarms (log must be kept on file)
- Unresolved symptomatic apnea

Diapers, under pads, liners/shields

Diapers, under pads, liners and shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for clients under three years of age or clients in long term care (nursing facility) settings.

Disposable diapers are limited to 180 diapers per month. Disposable under pads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year.

Electric breast pump

The use of an electric breast pump is considered medically appropriate if at least one of the following criteria is met:

- Client has a pre-term infant of 37 weeks or less gestation

Appendix A: Forms

- ***Montana Medicaid /MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***
- ***Certificates of Medical Necessity***
  - *Enteral Nutrition (CMS-853)*
  - *External Infusion Pump (CMS-851)*
  - *Hospital Bed (CMS-841)*
  - *Lymphedema Pumps (Pneumatic Compression Devices) (CMS-846)*
  - *Manual Wheelchairs (CMS-844)*
  - *Motorized Wheelchairs (CMS-843)*
  - *Osteogenesis Stimulators (CMS-847)*
  - *Oxygen (CMS-484)*
  - *Parenteral Nutrition (CMS-852)*
  - *Power Operated Vehicles (POV) (CMS-850)*
  - *Seat Lift Mechanisms (CMS-849)*
  - *Section C Continuation Form (CMS-854)*
  - *Support Surfaces (CMS-842)*
  - *Transcutaneous Electrical Nerve Stimulators (TENS) (CMS-848)*
- ***DMEPOS Medical Review Request Form***
- ***Request for Blanket Denial Letter***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604